

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>612 Elm Street</u>				d. STREET ADDRESS <u>222 Charles Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hunter</u> Last <u>Bittner</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1913</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - U.S.A.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>reserve center</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Bittner</u>				14. MOTHER'S MAIDEN NAME <u>Eva Jeannette Trimble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW II</u>		17. INFORMANT <u>Nevin T. Bittner</u>		222 <u>Charles Street,</u> <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>b:-----</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>April 17, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/ 20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>				ADDRESS <u>Cumberland Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF CALIFORNIA DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. RACE [REDACTED]</p>	
<p>5. DATE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF BIRTH [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. TIME OF DEATH [REDACTED]</p>		<p>10. CAUSE OF DEATH [REDACTED]</p>	
<p>11. MANNER OF DEATH [REDACTED]</p>		<p>12. MEDICAL HISTORY [REDACTED]</p>	
<p>13. PRESENT ILLNESS [REDACTED]</p>		<p>14. TREATMENT [REDACTED]</p>	
<p>15. SIGNATURE OF MEDICAL EXAMINER [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS [REDACTED]</p>		<p>22. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS [REDACTED]</p>		<p>28. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS [REDACTED]</p>		<p>34. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS [REDACTED]</p>		<p>40. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS [REDACTED]</p>		<p>46. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS [REDACTED]</p>		<p>52. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS [REDACTED]</p>		<p>58. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS [REDACTED]</p>		<p>64. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS [REDACTED]</p>		<p>70. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS [REDACTED]</p>		<p>76. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS [REDACTED]</p>		<p>82. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS [REDACTED]</p>		<p>88. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS [REDACTED]</p>		<p>94. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS [REDACTED]</p>		<p>100. SIGNATURE OF DECEASED [REDACTED]</p>	

4105

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>9 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>			d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>V.</u> Last <u>Blank</u>			4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rising Sun, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George A. Lewis</u>			14. MOTHER'S MAIDEN NAME <u>Susan Pond</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Erma J. Miller, Mt. Savage, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic - Hypertension</u> DUE TO (c) <u>Arteriosclerotic - Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>3/28</u> , 19 <u>60</u> , to <u>4/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/5/60</u> , 19 <u>60</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>48 Broadway</u> DATE SIGNED <u>4/7/60</u>					
ACTUAL SIGNATURE <u>Martin M. Rothstein</u> M.D.					
PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D. FROSTBURG MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. George Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence N. Leighty</u> ADDRESS <u>Hyndman, Pa.</u>			24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03996

4056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/17/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophia Middle Last Bockhouse		4. DATE OF DEATH Month April Day 25 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/1872
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own residence	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Bockhouse		14. MOTHER'S MAIDEN NAME Anna Walters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
INFORMANT P.O.Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 592X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Nephritis INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/17/58 , 19___, to 4/25/60 , 19___, that I last saw the deceased alive on 4/25/60 , 19___, and that death occurred at ___ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 4/26/60			
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/60	
22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE APR 29 '60		24b. REGISTRAR'S SIGNATURE Calvin S. Hines	

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DEPARTMENT OF HEALTH

40000

Allegany

Maryland

Allegany

Cumderland

11/17/58

Cumderland

105 Independence Street

Allegany County Jail

April 25, 1958

Bockmose

Sophia

87

9/20/1952

White

Female

U. S. A.

Cumderland, Maryland

Home - Domestic

None

Anna Walters

William Bockmose

Cumderland, Md.

P.O. Box 259

Allegany County Jail

None

No.

1/25/59

11/17/58

1/25/59

1/25/59

13 Greene St.

Cumderland, Md.

Dr. James H. Nolan

Cumderland, Md.

1/25/59

Allegany County Jail

MEDICAL CERTIFICATION

VS A15 (4)
15M, 9/58

2061298xv3

St. Patrick's Cemetery Mt. Savage, Md.

4-7-60

- 8 - Md.

B. H. H. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4107

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03998

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Edward Last Clark				4. DATE OF DEATH Month April Day 18th Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12th, 1879	
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mixer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward A. Clark				14. MOTHER'S MAIDEN NAME Emma Rossworm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-10-2276			
17. INFORMANT Mrs. Arnold Arnone, La Vale, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic Cardio - 443 DUE TO vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertension (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility INTERVAL BETWEEN ONSET AND DEATH 34 years. 30-4 years.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from 4-17 to 4-18 , 19 60 , that (I) was last saw the deceased alive on 4-17 19 60 and that death occurred at 6:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE H. C. Diehl				22b. DATE SIGNED 4/19/60			
22c. PHYSICIAN'S NAME (Type) H. C. Diehl,				22d. ADDRESS 39 W. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-20-60			
23c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park				23d. LOCATION (City, town, or county) (State) Frostburg, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Durst				25a. REC'D BY REGISTRAR APR 21 '60			
ADDRESS Frostburg, Md.				25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

08800

INDICATE OF DEATH

Illegible text, likely a form or document, with various fields and markings. The text is mirrored and difficult to read.

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4108

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03999

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 60 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 W. Main Street				d. STREET ADDRESS 60 W. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle E. Last Cobey				4. DATE OF DEATH Month April Day 27th Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15th, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.		IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander M. Earle				14. MOTHER'S MAIDEN NAME Mary Ellen Burns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT 819 Windsor Road, W. Earle Cobey, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH sudden several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 27 1960 to Apr 27 1960 that (I) (we) last saw the deceased alive on Apr 3 1960 and that death occurred 2:45 PM from the causes and on the date stated above.							
22a. SIGNATURE W O McLane				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) W. O. McLane				22d. ADDRESS 167 E. Main Street, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-60		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery, Arlington, Va.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR MAY 3 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

03900

STATE OF TEXAS

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03900

STATE OF TEXAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4057

CERTIFICATE OF DEATH

Reg. Dist. No. 04000

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> Rt. #1 Box #688	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>W.</u> Last <u>Coleman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-77</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired baker</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Coleman</u>	
14. MOTHER'S MAIDEN NAME <u>Malissa Hays</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>236-14-5884</u>		17. INFORMANT <u>Pt's chart.</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, chronic</u> <u>527.1</u> DUE TO (b) <u>Pulmonary Emphysema and Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Median Bar Prostate Hypertrophy & Interstitial Cystitis; Pneumonitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> Years _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December</u> , 19 <u>59</u> , to <u>April 11th</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 11th</u> , 19 <u>60</u> , and that death occurred at <u>2:35 P.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>W. Doerner</u> M.D.		PHYSICIAN'S NAME (Type) <u>W. Doerner, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Herman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		24a. REC'D BY REGISTRAR <u>APR 18 '60</u>	
ADDRESS <u>Cumberland Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

4003

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[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4109

CERTIFICATE OF DEATH

04001

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 Blair Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTIS ARTHUR COLEMAN</u>				4. DATE OF DEATH Month Day Year <u>4 29 19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hess</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-2110</u>		INFORMANT Address <u>Frostburg, Md.</u> <u>Mrs. Mary A. Bean, Coleman, 31 Blair St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> DUE TO <u>Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>Apr 29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Apr 28</u> , 19 <u>60</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W O McLane</u>		M.D. <u>W O McLane MD</u>		ADDRESS (Street, city or town, state) <u>Frostburg Md</u>		DATE SIGNED <u>4-30-60</u>	
PHYSICIAN'S NAME (Type) <u>W O McLane MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Winters</u>				ADDRESS <u>Hafer Funeral Home E. Main, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>			

10001

CERTIFICATE OF DEATH

11002

DEATH CERTIFICATE

John Doe

11002

4058 CERTIFICATE OF DEATH

Reg. Dist. No. 4002

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 527 Louisiana Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle LEONARD Last CRAMBLITT		4. DATE OF DEATH Month April Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY B & O Rwy.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Cramblitt		14. MOTHER'S MAIDEN NAME Eliza Rosebraugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Thomas Cramblitt Address 527 Louisiana Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis vascular disease 422.1 DUE TO (far advanced) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Amputation of leg, gangrene, 3.17.60			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-18-1959 to 4-30-1960 , that I last saw the deceased alive on 4-22-60 , and that death occurred at 3:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 5-2-60	
PHYSICIAN'S NAME (Type) Dr. W. F. Williams		122 S. Centre St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR MAY 4 60		24b. REGISTRAR'S SIGNATURE Charles L. George	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

1902

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

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1902

Vertical text on the right margin, likely a filing or archival note.

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4059

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04003

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		c. LENGTH OF STAY IN lb 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROY Middle E. Last CROWE		4. DATE OF DEATH Month APRIL Day 29 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1892
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) FINZEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS J. CROWE		14. MOTHER'S MAIDEN NAME MOLLIE BALLAH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 21B-10-9897	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longene small bowel 422.1 DUE TO Thrombosis superior mesenteric artery acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular disease (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Feb. 1960 to 29 Apr. 1960 , that (I) (we) last saw the deceased alive on 29 Apr. 1960 , and that death occurred at 9:05 PM on the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. VAN ORMER		22d. ADDRESS 747 WASHINGTON ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-2-60	
23c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery		23d. LOCATION (City, town, or county) (State) Garrett County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Frost		25a. REC'D BY REGISTRAR DATE MAY 4 '60	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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2700 S

THE UNIVERSITY OF CHICAGO

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PL 111-31297

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4110 - CERTIFICATE OF DEATH

04004
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 20 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Alleg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LONA CONING d. STREET ADDRESS 120 ALLEGANY ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle CUTTER Last CUTTER		4. DATE OF DEATH Month APRIL Day 24 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES DUCKWORTH		14. MOTHER'S MAIDEN NAME ANNIE MURPHY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT John Cutter Address Lonaconing, Md. "Husband"			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 24 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1st, 1960 , to 4-24 , 19 60 , that I last saw the deceased alive on 4-24 , 19 60 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William W. Lee M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 4/27/60	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR APR 27 '60 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 7 hours after death.

10001

1110

1110

George Washington

George Washington

1110

John Andrew
Washington

George Washington

George Washington

George Washington

George Washington

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **04005**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. # 51		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 213 Holland St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle LEE Last DEAN		4. DATE OF DEATH Month April Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1944
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None, (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Lee Dean		14. MOTHER'S MAIDEN NAME Hilda Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Hilda Dean		Address 213 Holland St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 823 x DUE TO XXXXXX Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Submerged with automobile in stream (b) 5 min. (c) 5 min.		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile went off road land into stream	
20c. TIME OF INJURY Month, Day, Year Hour 9:10 a. m. April 15, 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 51 south of Cumberland, Alleg. Md.		20f. (City or town) (County) (State) Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 15, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/60	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24a. REC'D BY REGISTRAR Arthur L. Kraus	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IRVING STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

823X

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
BALTIMORE		MD.		U.S.A.		1925		HOSPITAL		HEART DISEASE	
MANNER OF DEATH		DISEASE		INJURY		POISON		OTHER		REMARKS	
NATURAL		CORONARY ARTERY DISEASE									
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		SIGNATURE OF EXAMINER		DATE OF SIGNATURE		PLACE OF SIGNATURE	
1925		BALTIMORE		J. H. HARRIS		[Signature]		1925		BALTIMORE	

4060

CERTIFICATE OF DEATH

Reg. 4006

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>532 Green St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Denson</u> Last <u>Denson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>08.24.1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Rob Massey</u>				14. MOTHER'S MAIDEN NAME <u>Anna V. Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Niece- Elizabeth Harris</u> Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>45 min.</u> <u>6 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-22-1960</u> to <u>4-23-1960</u> that I last saw the deceased alive on <u>4-22-1960</u> , and that death occurred at <u>5:41 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Brings</u>				ADDRESS (Street, city or town, state) <u>57 GREENE ST.</u>		DATE SIGNED <u>4-24-60</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS</u>				<u>Cumberland Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stern Inc. - Cumber</u>				ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1900

CERTIFICATE OF DEATH

1900



1900



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1900

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04007
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>702 N. Mechanic Street</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02. Cumberland</u> d. STREET ADDRESS <u>702 N. Mechanic Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>HAROLD</u> <u>THOMAS</u> <u>DEVAULT</u> First Middle Last				4. DATE OF DEATH <u>April 22</u> 19 <u>60</u> Month Day Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1908</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brewery wkr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland Brew-</u>				11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN WILLIAM DEVAULT</u>						14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH MILLS</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT <u>John Wm. Devault, Rt. 4, Mt. Airy, Maryland</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.												INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <u>Cumberland, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Richard Williams</u>						EXAMINER'S NAME (Type) <u>Richard Williams M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>April 23, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/25/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u> ADDRESS						24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>					

MEDICAL CERTIFICATION

 TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

4001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED (Print or type name in full)		DATE OF DEATH (Month, day, year)	
PLACE OF DEATH (City, town, or village)		COUNTY OF DEATH (County)	
SEX OF DECEASED (Male or Female)		AGE OF DECEASED (Years, months, days)	
OCCUPATION OF DECEASED (If deceased was engaged in any occupation)		CAUSE OF DEATH (State in full)	
MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal, Undetermined)		SIGNATURE OF MEDICAL EXAMINER (Print name and sign)	
SIGNATURE OF WITNESS (Print name and sign)		SIGNATURE OF DECEASED (If deceased was capable of signing)	
SIGNATURE OF NEXT OF KIN (Print name and sign)		SIGNATURE OF BURIAL OFFICIAL (Print name and sign)	
SIGNATURE OF CLERK (Print name and sign)		SIGNATURE OF REGISTRAR (Print name and sign)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
4062
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04008

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 18 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY TYLER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SISTERSVILLE d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First A Middle EMERSON Last DOAK		4. DATE OF DEATH Month APRIL Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 21, 1876
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (State or foreign country) DEEP VALLEY, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT DOAK		14. MOTHER'S MAIDEN NAME INGABE BEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-20-60 to 4-20-60 , that (I) (we) last saw the deceased alive on 4-20-60 and that death occurred 12:50 PM from the causes and on the date stated above.			
22a. SIGNATURE W. F. WILLIAMS M.D.		22b. DATE 4-21-60 SIGNED	
22c. PHYSICIAN'S NAME (Type) W. F. WILLIAMS		22d. ADDRESS Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 23, 1960	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) Sistersville, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR DATE APR 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

80020

CERTIFICATE OF DEATH

80020

1

LOCAL RESIDENCE

STATE

DATE

DEATH LOCATION

DEATH TIME

DEATH CAUSE

DEATH PLACE

DEATH PLACE

DEATH PLACE

DEATH PLACE

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DEATH PLACE

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Page 4
after death.
The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4063 9 Film 6263 5/11/60 1wk
CERTIFICATE OF DEATH

04009

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL (If not hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last DOWDEN		4. DATE OF DEATH Month APRIL Day 30 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 3, 1903
9. AGE (In years lost birthday) 56 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman Helper	11. BIRTHPLACE (State or foreign country) FORT ASHBY, W. VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES DOWDEN	
14. MOTHER'S MAIDEN NAME MARY ALLEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 705-07-9752		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO carcinoma pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 weeks ?			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-2-1 19 60 to 4-30 19 60 that (I) (we) last saw the deceased alive on 4-30 19 60 , and that death occurred at 2:05 P.M. because of carcinoma pancreas and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 5-2-60	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 NORTH CENTRE, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 3, 1960	23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery	23d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25. REC'D BY REGISTRAR DATE MAY 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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CENTRAL LIFE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/2/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Dunlap		4. DATE OF DEATH Month April Day 14 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Hyndman, Pennsylvania	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Dunlap		14. MOTHER'S MAIDEN NAME Lydia Martz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion 350 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis DUE TO (c) Parkinson's Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Deterioration.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2/60 , 19___, to 4/14/60 , 19___, that I last saw the deceased alive on 4/13/60 , 19___, and that death occurred at 5:10AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 4/14/60			
ACTUAL SIGNATURE James E. McLean		M.D. 49 Greene St.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS 49 Greene St.	
DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Anthony J. Hafer	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

352

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Allegany

Allegany

Allegany

Allegany

3/2/60

Allegany

Allegany County Jail

Allegany County Jail

Western

Western

April 11, 1960

Male

White

10/7/1932

6'0"

Reflected Auto Records

Charles G. Galt

Lydia Galt

Allegany County Jail

3/2/60

3/2/60

3/2/60

Allegany

Dr. James E. Johnson

April 10, 1960

John A. Miller, Sheriff

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4111

CERTIFICATE OF DEATH

Reg. Dist. No. **44011**

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>13 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Barton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>Mae</u> Middle <u>Dye</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1917</u>		9. AGE (In years last birthday) <u>42</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Shuhart</u>				14. MOTHER'S MAIDEN NAME <u>Florence Magruder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <u>Cecil Dye</u>		Address <u>Barton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>584X</u> DUE TO <u>Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Post operative Complication</u> (c) <u>Biliary obstruction - stones</u>							INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u> <u>6 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity!!</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1959</u> , to <u>April 9, 1960</u> , that I last saw the deceased alive on <u>4-8-60</u> , 19 <u>60</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westernport, Md.</u>							
ACTUAL SIGNATURE <u>William W. Lesh M.D.</u> M.D.				DATE SIGNED <u>4-10-60</u>			
PHYSICIAN'S NAME (Type) <u>William W. Lesh, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>La Vale Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Boral</u>				ADDRESS <u>Westernport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CHIEF OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4065

CERTIFICATE OF DEATH

Reg. Dist. No. 4012

1. PLACE OF DEATH a. COUNTY Maryland			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Bedford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 3 Bedford		75x-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Julia Middle Elizabeth Last Early			4. DATE OF DEATH Month 4 Day 5 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/96	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois Mt. Carmel		12. CITIZEN OF WHAT COUNTRY? Ill. U.S.A.
13. FATHER'S NAME August Kellersohn			14. MOTHER'S MAIDEN NAME Johanna Altoff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	INFORMANT Chart Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and CARDIAC Failure 560.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Refractive obstruction of Bowel (c) Hemian and Diverticulitis					INTERVAL BETWEEN ONSET AND DEATH 9 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity - Poor CARDIAC RESERVE					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 3-23, 1960 , to 4-5, 1960 , that I last saw the deceased alive on 4-5, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Carlton Brinsfield		M.D.			
PHYSICIAN'S NAME (Type) Dr. Carlton Brinsfield		232 Baltimore Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-60		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.	
22d. LOCATION (City, town, or county) (State) Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanes					

CERTIFICATE OF DEATH

Reg. No. 4066-1013

4066

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY, Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 445 Chesnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELMER EARL FETTERS		4. DATE OF DEATH Month APRIL Day 22 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1891
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY B & O Freight Trucker	
11. BIRTHPLACE (State or foreign country) Defiance, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Franklin Feters		14. MOTHER'S MAIDEN NAME Carrie Cartwright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF RIGHT LUNG DUE TO (c) PROSTATIC HYPERTROPHY		INTERVAL BETWEEN ONSET AND DEATH 3 mos 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PROSTATIC HYPERTROPHY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1960 to April 22, 1960 that I last saw the deceased alive on April 20, 1960 , and that death occurred at 5:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Greene St. Cumberland, Md DATE SIGNED 4/23/60			
ACTUAL SIGNATURE S. G. Weisman M.D.		PHYSICIAN'S NAME (Type) S. G. Weisman M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/60	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE APR 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4013

CERTIFICATE OF DEATH

1900

1. Name of deceased: John J. Taylor
2. Sex: Male
3. Age: 45 years
4. Date of death: Jan. 15, 1900
5. Place of death: Home, 1234 Main St., New York, N.Y.
6. Cause of death: Heart disease
7. Signature of physician: Dr. J. J. Taylor
8. Signature of registrar: John J. Taylor
9. Name of registrar: John J. Taylor
10. Address of registrar: 1234 Main St., New York, N.Y.

CERTIFICATE OF DEATH

Reg. Dist. No. **44014****4067**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 33 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 621 Fairview Ave.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Austin Middle Adam Last Free				4. DATE OF DEATH Month 4 Day 12 Year 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/77			
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stone Mason				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Issac Free				14. MOTHER'S MAIDEN NAME Melvina Lintz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None					
17. INFORMANT Chart				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) lying cause lost.								INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Liver								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-11 , 19 60 to 4-12 , 19 60 that I last saw the deceased alive on 4-12 , 19 60 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-14-60									
ACTUAL SIGNATURE William P. James M.D.									
PHYSICIAN'S NAME (Type) Dr. E. P. James				441 N Centre Street Cumberland Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/15/60		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md		24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1905

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Allegany

YES ☐ NO ☒

U.S.A.

Husband- William M. Goldsborough. Sr.

INTERVAL BETWEEN
ONSET AND DEATH

Hypertensive Cardio-Vascular Renal Disease

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

(State)

DATE SIGNED _____

Cumberland Ind

(Statel

24b. REGISTRAR'S SIGNATURE

[illegible]

1015

CERTIFICATE OF DEATH

1015

STATE OF NEW YORK
COUNTY OF ALBANY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4069

CERTIFICATE OF DEATH

04016
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/14/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle William Last Grandstaff		4. DATE OF DEATH Month April Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Janitor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Grandstaff		14. MOTHER'S MAIDEN NAME Katie Clise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-18-1809	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/14/57 , 19____, to 4/1/60 , 19____, that I last saw the deceased alive on 4/1/60 , 19____, and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 4/2/60			
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/60	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md/	
23. FUNERAL DIRECTOR'S SIGNATURE E. Spinal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR APR 6 1960		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

508071 CERTIFICATE OF DEATH

Allegany Maryland Allegany

9/1/57 Cumberland

Allegany County Infirmary

James Clarence William Grandstaff
Male White x 2/15/1880 80

Resided - Union

Virginia

U. S. A.

Joseph Grandstaff

Male Ohio

P.O. Box 999

Cumberland, Md.

Allegany County Infirmary Record

9/1/57 11/1/50

My Green St.

11/2/50

Cumberland, Md.

Dr. James E. Nelson

04017

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
BURIAL	APR. 12, 1960	F'BG. MEMORIAL	FROSTBURG,	MD.
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
<i>J. K. Hurst</i>		FROSTBURG, MD.	APR 13 '60	<i>Arthur S. Thomas</i>

VR A1S (4)
ISM 9/59

01010

CERTIFICATE OF DEATH

4118

420.0



4070

CERTIFICATE OF DEATH

04018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 Pear St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Francis Hannon</u>		4. DATE OF DEATH Month Day Year <u>April 8 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1890</u>
9. AGE (in years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Barton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Joseph Hannon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Frances Burke, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma of Lung</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma Breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH ? <u>10 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-6</u> , 19 <u>57</u> , to <u>4-8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-7-60</u> , 19 <u>60</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William P. James</u> M.D. <u>441 N. CENTRE STREET</u> <u>4-8-60</u>		PHYSICIAN'S NAME (Type) <u>WILLIAM P. JAMES, M.D. CUMBERLAND, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 11, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc. Cumberland, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

154X

4071

CERTIFICATE OF DEATH

04019
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md			
c. LENGTH OF STAY IN 1b 4/20/60				d. STREET ADDRESS 209 1/2 Carroll Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Franklin Last Heavner		4. DATE OF DEATH Month 4 Day 22 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-86	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Hyre				14. MOTHER'S MAIDEN NAME Hannah Whetzel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Patient's Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 7 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-9-53 , 19____, to 4-22-60 , 19____, that I last saw the deceased alive on 4-22-60 , 19____, and that death occurred at 7:45M , from the causes and on the date stated above.							
ACTUAL SIGNATURE RW Beemer				ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md.			
DATE SIGNED 4-23-60							
PHYSICIAN'S NAME (Type) Dr. R. W. Ballin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/60		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE APR 26 '60	
				24b. REGISTRAR'S SIGNATURE Charles L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a legal or official record, with several lines of text visible across the page.]

4072

CERTIFICATE OF DEATH

Reg. Dist. No.

04020

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/11/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Regina Last Hoss		4. DATE OF DEATH Month April Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1866
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Milkowski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT P.O. Box 599, Address Cumberland, Md.	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension 422.2 DUE TO Chronic Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral arteriosclerosis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 2/11/59 , 19___, to 4/13/60 , 19___, that I last saw the deceased alive on 4/12/60 , 19___, and that death occurred at 3:40 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. 4/13/60	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 4/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-60	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Surt ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE Apr 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

334X

4073

CERTIFICATE OF DEATH

04021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/8/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Zane Middle Hill Last Hinkle		4. DATE OF DEATH Month April Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1890
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Kitchen Helper (Hospital)		10b. KIND OF BUSINESS OR INDUSTRY (State) Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Zane C. Hinkle		14. MOTHER'S MAIDEN NAME Eliza Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-5194	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO Senile arteriosclerosis (c) Chronic Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/8/58 , 19___, to 4/13/60 , 19___, that I last saw the deceased alive on 4/12/60 , 19___, and that death occurred at 1:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 4/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/60	
22c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

491X

62/81/3

C123

Figure 1

Winkler

07

0001/2/2

[illegible]

Journal of Interpersonal Violence 25(10)

Allegany County Jail, Maryland

15/3/06

82/5/0

0-000000

1. The first of these is the fact that the Commission has not yet received any information from the Government of the Republic of China (Taiwan) regarding the situation in the Republic of China (Taiwan) since the end of the Second World War.

06/25/01

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04022

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 25 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford		85X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Samuel Middle W. Last Hott				4. DATE OF DEATH Month April Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farmer for Self		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Hott				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Memorial Hospital, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 8 Hrs. ---
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 13, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/16/60		22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cem. Key West, Florida		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc				ADDRESS Cumb-Md		24a. REC'D BY REGISTRAR DATE APR 18 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

420.0

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		80		1870		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		RETIRED		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
APRIL 12, 1950		10:15 AM		10:15		00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF EXAMINATION		TIME OF EXAMINATION		HOUR OF EXAMINATION		MINUTE OF EXAMINATION		SECOND OF EXAMINATION	
APRIL 12, 1950		10:15 AM		10:15		00		00	
PLACE OF EXAMINATION		OCCUPATION OF EXAMINER		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		RETIRED		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS R.F.D.#1	
3. NAME OF DECEASED (Type or print) First CHARLES Middle D Last KENNEY		4. DATE OF DEATH Month APRIL Day 13 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 11 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saw Mill		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
11. BIRTHPLACE (State or foreign country) SPRINGFIELD, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OKIE KENNEY		14. MOTHER'S MAIDEN NAME SALLY CHANEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Benign hypertrophy prostate 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis & anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-24-60 to 4-13-60 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 1:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Howard Tolson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HOWARD TOLSON		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-60	
23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem		23d. LOCATION (City, town, or county) (State) Fort Ashby, W.Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR DATE APR 18 60		25b. REGISTRAR'S SIGNATURE Wm. S. Thayer	

1902

CERTIFICATE OF DEATH

1902

610x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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4076
MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH
64025

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3HRS.55 MIN. 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1. d. STREET ADDRESS 782 FAYETTE STREET	
3. NAME OF DECEASED (Type or print) First JAMES Middle Weir Last KIRK				4. DATE OF DEATH Month APRIL Day 22 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 22, 1891 69 yrs.	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inspect. Accts. B. & O. Rwy		10b. KIND OF BUSINESS OR INDUSTRY Glasgow, Scotland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES KIRK			
14. MOTHER'S MAIDEN NAME Anna WEIR				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease (acute congestive failure) DUE TO Several days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Several days DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Several days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1.9.1958 to 4.22.1960 that (I) met last saw the deceased alive on 4.22.1960 and that death occurred 7:45 PM from the causes and on the date stated above.				22a. SIGNATURE W.F. Williams M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED 4-25-60				22c. PHYSICIAN'S NAME (Type) W.F. WILLIAMS M.D.			
22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MARYLAND				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 4/25/60				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Maryland				25a. REC'D BY REGISTRAR APR 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

WILLIAM

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HOSPITAL, CHICAGO, ILL.

4077

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/21/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle G. Last Kylus		4. DATE OF DEATH Month April Day 1, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/1880
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Vincent Kylus		14. MOTHER'S MAIDEN NAME Mary Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT P.O. Box 599 Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Arthritis Deformans		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21/56 , 19____, to 4/1/60 , 19____, that I last saw the deceased alive on 4/1/60 , 19____, and that death occurred at 6:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/2/60	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/60	
22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cath. Church Cem.		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 5 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

Allegany

Maryland

Allegany

Camden

1/21/36

Camden

Allegany County Infirmary

119 Louisiana Avenue

John

G.

Kyle

April

79

2/21/38

X

White

Male

Heidelberg - Taylor

Taylor

Richmond

U. S. A.

Vincent Ryan

Kyle

P.O. Box 299

Allegany County Infirmary Records

1/21/36

1/21/36

1/21/36

119 Greene Street

Camden, Maryland

Dr. James E. Nolan

2/21/38

Burial

John J. Taylor, Camden, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

4078

64027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MELVIN M. LANCASTER				4. DATE OF DEATH Month Day Year APRIL 5 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 23, 1941	
9. AGE (In years lost birthday) 18 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ARGYLE LANCASTER				14. MOTHER'S MAIDEN NAME NELLIE AIRHART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive Heart Failure DUE TO Pneumonia bilateral DUE TO Rheumatic Heart Disease - mitral stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from July 1959 to April 5, 1960 , that (I) (we) last saw the deceased alive on April 5, 1960 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Wyand B Doerner				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. WYAND DOERNER				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 8, 1960		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg Md	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer				ADDRESS Cumberland Md		25a. REC'D BY REGISTRAR DATE APR 11 '60	
						25b. REGISTRAR'S SIGNATURE J. J. Hafer	

15711

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DEATH CERTIFICATE

DATE

TIME

PLACE

BY

AGE

SEX

RACE

EDUCATION

HEIGHT

WEIGHT

TEMPERATURE

PULSE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

DIAPHRAGM

SKIN

HAIR

EYES

EARS

NOSE

MOUTH

THROAT

STOMACH

INTESTINES

BLADDER

RECTUM

GENITALS

TEETH

TOOTHACHE

TOOTH LOSS

TOOTH DISEASE

TOOTH EXAMINATION

TOOTH TREATMENT

TOOTH SURGERY

TOOTH PROSTHESIS

TOOTH BRUSHING

TOOTH FLOSSING

TOOTH POLISHING

TOOTH WHITENING

TOOTH COATING

TOOTH SEALING

TOOTH CROWNING

TOOTH BRIDGING

TOOTH IMPLANTATION

TOOTH EXTRACTION

TOOTH REPLACEMENT

TOOTH REPAIR

TOOTH RESTORATION

TOOTH MAINTENANCE

TOOTH PROTECTION

TOOTH PRESERVATION

TOOTH REGENERATION

TOOTH REPAIRMENT

TOOTH RECONSTRUCTION

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4079

Item 9 Film G261 4/25/60 cap

CERTIFICATE OF DEATH

04028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 26 Utah St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 26 Utah St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harold D. Linn		4. DATE OF DEATH Month Day Year April 19, 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1918
9. AGE (In years last birthday) 41 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Engineer II		10b. KIND OF BUSINESS OR INDUSTRY Md. State Road	
11. BIRTHPLACE (State or foreign country) Comm. Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Linn		14. MOTHER'S MAIDEN NAME Geraldine Binnix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-07-3075	
17. INFORMANT Address Mrs. Geraldine Linn, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/25 , 19 60 , to 4/18 , 19 60 , that I last saw the deceased alive on 4/16 , 19 60 , and that death occurred at 4:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leo H. Ley, Jr. M.D. 456 N. Centre St. 4/20/60 PHYSICIAN'S NAME (Type) Dr. Leo H. Ley, Jr. Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR APR 21 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4080 CERTIFICATE OF DEATH

64029

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 46 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BEATRICE Middle MARY Last LITTLE		4. DATE OF DEATH Month APRIL Day 30 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b. KIND OF BUSINESS OR INDUSTRY Jewelry Store	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES STORER		14. MOTHER'S MAIDEN NAME MARY ANN CLARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-22-6698	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 46 days 4-5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-21 19 60 to 4-30 19 60 that (I) (we) last saw the deceased alive on 4-30 19 60 and that death occurred at 4:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William P. Scarpelli		22b. DATE SIGNED 5-3-60	
22c. PHYSICIAN'S NAME (Type) DR. JAMES		22d. ADDRESS 441 NORTH CENTRE, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 3, 1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 4 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE W. L. H. H.	

1000

CERTIFICATE OF DEATH

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MINISTERS

ALLIANCE

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10 DAYS

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MEDICAL CERTIFICATION

4081 CERTIFICATE OF DEATH

04030

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 2 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 513 E. PRINCE GEORGE STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS W. LLOYD				4. DATE OF DEATH Month APRIL Day 2 Year 19 60				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3 1919		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED			10b. KIND OF BUSINESS OR INDUSTRY Bowling Alley		11. BIRTHPLACE (State or foreign country) MIDLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. LLOYD				14. MOTHER'S MAIDEN NAME KR ELIZABETH KRAUSS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) War II 218-34-4740		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, hypertrophic, liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-15-58 to 4-2-60 , 19____, that (I) (we) last saw the deceased alive on 4-1-60 19____, and that death occurred at 2:50 AM M., from the causes and on the date stated above.								
22a. SIGNATURE Ralph W. Ballin				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-2-60		
22c. PHYSICIAN'S NAME (Type) DR. RALPH BALLIN				22d. ADDRESS 62 Greene St. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-4-60	23c. NAME OF CEMETERY OR CREMATORY Zion Evangelical Reform Cem. Frostburg, Md.			23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE APR 6 '60		
25b. REGISTRAR'S SIGNATURE Arthur S. Kline								

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ALLIANCE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4113 CERTIFICATE OF DEATH

04031

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALFRED F. LORAW				4. DATE OF DEATH Month Day Year 4/5/1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Retired--Steelworker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pekin, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harrison Loraw				14. MOTHER'S MAIDEN NAME Floney Simons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-01-6666		17. INFORMANT Address Mrs. Catherine Loraw, Midland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Acute left ventricular failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Rheumatoid Arthritis Gastric Ulcer						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 22 1959 to April 5 1960 that (I) (we) last saw the deceased alive on April 5 1960 , and that death occurred at 7pM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-7-60	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.				22d. ADDRESS LONACONING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/1960		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town, or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GEORGE EICHORN LONACONING, MD.				25a. REC'D BY REGISTRAR DATE APR 11 '60		25b. REGISTRAR'S SIGNATURE [Signature]	

1881

THE UNIVERSITY OF CHICAGO

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64032

4114 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg (Rural Wright's Crossing</u>			
				d. STREET ADDRESS <u>Rt. #1, Box 16</u>			
3. NAME OF DECEASED (Type or print) First <u>Christina</u> Middle <u>McDonald</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-1884</u>	
				9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Shaft, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Schell</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Weymer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Paul Whitefield, Rt. No. 1,</u>				Address <u>Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial exhaustion</u> <u>586 X</u> DUE TO <u>Generalized Toxemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatic trauma</u> DUE TO (c) <u>Obstruction of Ductus Choledochus</u> INTERVAL BETWEEN ONSET AND DEATH <u>± 4 hrs</u> <u>48 hrs</u> <u>± 15 d</u> <u>15 d.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Frostburg</u>		(County) (State)	
21. I certify that I attended the deceased from <u>3/29</u> , <u>1960</u> to <u>4/3</u> , <u>1960</u> , that I last saw the deceased alive on <u>4/3</u> , <u>1960</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>26 W. Mechanic St.</u> <u>4/5/60</u>							
ACTUAL SIGNATURE <u>Frank T. Harrat</u>				M.D. <u>26 W. Mechanic St.</u>			
PHYSICIAN'S NAME (Type) <u>FRANK T. HARRAT</u>				<u>Frostburg Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> <u>Beulah H. Montes</u> <u>23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4082

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 4. DATE OF DEATH		Month Day Year	
First <u>Theresa</u> Middle <u>Estell</u> Last <u>Miller</u>		<u>4/</u> <u>11</u> <u>19 60</u>	
5. SEX <u>F</u> male	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Eckhart, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Dennis O'Hara</u>		14. MOTHER'S MAIDEN NAME <u>Janet Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No,</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Loretta Cassen</u>		Address <u>Cumberland, Md. 551 N. Mechanic St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Poisoning</u>			
<u>782.4</u> DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>Myocardial Failure</u>			
DUE TO			
(c) <u>Generalized Visceral failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced age</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1960</u> to <u>April 11, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 11, 1960</u> , and that death occurred at <u>1:20 a.m.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James P. Hallinan M.D.</u>		22b. DATE SIGNED <u>4/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.P. Hallinan, M.D.</u>		22d. ADDRESS <u>140 Bedford Street, Cumberland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/13/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul's</u>	23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		24b. ADDRESS <u>Cumberland, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

0303

CERTIFICATE OF DEATH

4.287

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4115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. STREET ADDRESS 77 Armstrong Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARTHA VERONICA MONSEN				4. DATE OF DEATH Month Day Year 4 26 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-4-1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Westernport, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick Griffin				14. MOTHER'S MAIDEN NAME Margaret McGuire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Ernest Monsen				Address Grahamtown, Md. 77 Armstrong St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute hepatitis DUE TO (c) arterio sclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 wk ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr 5 , 19 60 , to Apr 26 , 19 60 , that I last saw the deceased alive on Apr 25 , 19 60 , and that death occurred at 4:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMcLane M.D.				ADDRESS (Street, city or town, state) Frostburg DATE SIGNED Apr 27 1960			
PHYSICIAN'S NAME (Type) WOMcLane M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-60		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Boulah H. Monticent ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR MAY 2 '60		24b. REGISTRAR'S SIGNATURE William S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

CERTIFICATE OF DEATH

1110

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

4083

4083

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

64035

1. PLACE OF DEATH a. COUNTY ALLEGANY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 31 DAYS			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CRESAPTOWN			d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) SAMUEL			First Boyd			Middle MOON			Last MOON			4. DATE OF DEATH APRIL			Month 18			Day 1960							
5. SEX MALE			6. COLOR OR RACE WHITE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH SEPTEMBER 5, 1888			9. AGE (In years lost birthday) 71 yrs.			IF UNDER 1 YEAR Months 7 Days 13			IF UNDER 24 HRS. Hours — Min. —							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith						10b. KIND OF BUSINESS OR INDUSTRY Coal Mine						11. BIRTHPLACE (State or foreign country) W. Va.						12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JACOB MOON									14. MOTHER'S MAIDEN NAME ANNA DINNIT																
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes, give year or dates of service) No			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address																
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Chronic bronchitis - Diabetes DUE TO Complications of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO — (c) —																		INTERVAL BETWEEN ONSET AND DEATH 42 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —						20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland						20f. (City or town) Allegany (County) MD (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/17/60 19 to 4/18/60 19, that (I) (we) last saw the deceased alive on 4/17/60 19, and that death occurred at 5:55 AM from the causes and on the date stated above.																									
22a. SIGNATURE DR. R. J. WILLIAMS. M.D.																		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/19/60	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS.																		22d. ADDRESS Cumberland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 4-20-60						23c. NAME OF CEMETERY OR CREMATORY White Church Cemetery						23d. LOCATION (City, town, or county) Loch Lynn, Md. (Garrett) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Thomas R. Smith Jr.																		ADDRESS Keyser, W. Va.		25a. REC'D BY REGISTRAR APR 21 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

260x

White Church Cemetery, 1000 N. 4th St.,
St. Paul, Minn.

St. Paul, Minn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A1S (4)
15M 9/59

64036

1. PLACE OF DEATH o. COUNTY		ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		MARYLAND		b. COUNTY		ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		c. LENGTH OF STAY IN 1b		13 1/2 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MEMORIAL HOSPITAL		d. STREET ADDRESS		321 NORTH CENTRE STREET		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year	
		ELEANOR		H		MORLEY		APRIL		21		19 60	
5. SEX		FEMALE		6. COLOR OR RACE		WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		JANUARY 1, 1880	
9. AGE (In years last birthday) yrs.		80		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		At Home		11. BIRTHPLACE (State or foreign country)	
												CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME		Harry HENRY HORN		14. MOTHER'S MAIDEN NAME		FRANCES RIDENOUR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.				17. INFORMANT		Address		MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Acute Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio - Vascular Disease (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 4/20 1960, to 4/21 1960, that (I) (we) last saw the deceased alive on 4/20 1960, and that death occurred 02:00 AM on the date stated above.													
22a. SIGNATURE		Leo H. Ley		22b. DATE SIGNED		4/21/60							
22c. PHYSICIAN'S NAME (Type)		LEO H. LEY		22d. ADDRESS		Cumberland, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		4/23/60		23c. NAME OF CEMETERY OR CREMATORY		Rosehill Mausoleum		23d. LOCATION (City, town, or county) (State)	
												Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		Ruth E. Silcox		Cumberland		Maryland		25a. REC'D BY REGISTRAR		DATE		25b. REGISTRAR'S SIGNATURE	
										APR 26 '60		Carlton S. Kraus	

CERTIFICATE OF DEATH

6083

ALLEGY

CONSTITUTION

1901

301 NORTH CENTRE STREET

WILSON

WILSON

WILSON

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WILSON

2 1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4124

4124

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ECKHART		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WAYNE First WILLIAM E. Middle MYERS Last		4. DATE OF DEATH APRIL Month 16, Day 1960 Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY BALLISTIC PLANT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN D. MYERS		14. MOTHER'S MAIDEN NAME CATHERINE GOODMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-09-6422	
17. INFORMANT MRS. ORA S. MYERS, ECKHART, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular failure 260X DUE TO Myocardial fibrosis, coronary arteriosclerosis, left ventricular hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH sudden ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/2 19 57 to 4/16 19 60 that (I) (we) last saw the deceased alive on 4/2/ 19 60 , and that death occurred at 6P M, from the causes and on the date stated above.		22a. SIGNATURE DR. SAMUEL JACOBSON M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4/18/60	
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON		22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-19-1960	
23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City, town, or county) (State) ECKHART, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FROSTBURG, MD.		25a. REC'D BY REGISTRAR APR 20 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

1125 - CENTRAL OF MARYLAND

1

APPLICANT

NAME

STREET

CITY

STATE

DATE

TIME

BY

NAME

DATE

TIME

NAME

STREET

CITY

STATE

DATE

STREET

CITY

STREET

STREET

1

2

3

4

5

1125

STREET

STREET

1125

STREET

4121

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>ANN</u> Last <u>NEDER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Lapp</u>		14. MOTHER'S MAIDEN NAME <u>Anna Everline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Raymond Neder,</u>		Address <u>Mt. Savage, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> <u>15 yrs.??</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>1960</u> , that I last saw the deceased alive on <u>19 60</u> , and that death occurred at <u>4:47 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Martin M. Rothstein M.D.</u> M.D. <u>48 Broadway</u> PHYSICIAN'S NAME (Type) <u>Martin M. Rothstein M.D.</u> <u>Frostburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. George Epis. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
ADDRESS <u>Frostburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Funder</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

4200

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4085
CERTIFICATE OF DEATH

64039

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 221 SPRINGDALE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JENNIE First L. Middle NIXON Last		4. DATE OF DEATH Month APRIL Day 5 Year 1960					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1880	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) OLDTOWN, MD.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Seaton			14. MOTHER'S MAIDEN NAME Ruth Ann DU VALL				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated small intestine 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mesenteric thrombosis DUE TO (c) arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 1 week " "		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. p. m. of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/2 1960 to 4/5 1960 , that (I) (we) last saw the deceased alive on 4/4 1960 , and that death occurred at 4:00AM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22b. DATE SIGNED 4/6/60			
22d. ADDRESS Cumberland, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-8-60		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.			
23d. LOCATION (City, town, or county) (State) Cumberland, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE APR 11 '60		
			25b. REGISTRAR'S SIGNATURE [Signature]				

05030

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
OFFICE OF THE ASSISTANT ATTORNEY GENERAL
BUREAU OF VITAL RECORDS
DIVISION OF DEATH RECORDS

05030

NAME OF DECEASED: [REDACTED] SEX: [REDACTED] AGE: [REDACTED] RACE: [REDACTED]

DATE OF DEATH: [REDACTED] TIME OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED] MANNER OF DEATH: [REDACTED]

DECEASED'S RESIDENCE: [REDACTED] DECEASED'S OCCUPATION: [REDACTED]

DECEASED'S MARITAL STATUS: [REDACTED] DECEASED'S RELIGION: [REDACTED]

DECEASED'S EDUCATION: [REDACTED] DECEASED'S SERVICE: [REDACTED]

DECEASED'S SOCIAL SECURITY NUMBER: [REDACTED] DECEASED'S BIRTH DATE: [REDACTED]

DECEASED'S BIRTH PLACE: [REDACTED] DECEASED'S BIRTH TIME: [REDACTED]

DECEASED'S BIRTH WEIGHT: [REDACTED] DECEASED'S BIRTH LENGTH: [REDACTED]

DECEASED'S BIRTH HEAD CIRCUMFERENCE: [REDACTED] DECEASED'S BIRTH SKIN COLOR: [REDACTED]

DECEASED'S BIRTH HAIR COLOR: [REDACTED] DECEASED'S BIRTH EYE COLOR: [REDACTED]

DECEASED'S BIRTH BUILD: [REDACTED] DECEASED'S BIRTH DENTAL RECORD: [REDACTED]

DECEASED'S BIRTH SPECIAL FEATURES: [REDACTED] DECEASED'S BIRTH SPECIAL TREATMENT: [REDACTED]

DECEASED'S BIRTH SPECIAL NOTES: [REDACTED] DECEASED'S BIRTH SPECIAL COMMENTS: [REDACTED]

DECEASED'S BIRTH SPECIAL SIGNATURE: [REDACTED] DECEASED'S BIRTH SPECIAL INITIALS: [REDACTED]

DECEASED'S BIRTH SPECIAL STAMP: [REDACTED] DECEASED'S BIRTH SPECIAL MARKS: [REDACTED]

DECEASED'S BIRTH SPECIAL PHOTOGRAPH: [REDACTED] DECEASED'S BIRTH SPECIAL X-RAY: [REDACTED]

DECEASED'S BIRTH SPECIAL OTHER: [REDACTED] DECEASED'S BIRTH SPECIAL REMARKS: [REDACTED]

4086 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1912 Frederick St.</u>				d. STREET ADDRESS <u>1912 Frederick St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>P</u> Last <u>O'Rourke</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1913</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Supt. Celenese Corp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>Midland, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Patrick O'Rourke</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth McMahon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>214-07-2815</u>		17. INFORMANT <u>Elizabeth C. O'Rourke</u>		Address <u>Cumberland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OBLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4-10</u> , 19 <u>60</u> , to <u>4-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>232 Baltimore Ave</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Carlton Brinsfield</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>CARLTON BRINSFIELD M.D.</u> <u>Cumberland Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stern, Inc.</u> ADDRESS <u>Cumberland, Md</u>				24a. REC'D BY REGISTRAR <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Brinsfield</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4116 CERTIFICATE OF DEATH

64041

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 4 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Porter				4. DATE OF DEATH Month April Day 21st Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30th, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Brown				14. MOTHER'S MAIDEN NAME Helena Hobell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-09-6475		17. INFORMANT Wm. Porter, Rt. 3, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epithelioma left Vulva with 176.0 DUE TO Abdominal Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO Hypertension (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 years.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 10, 1958 to April 21, 1960 , that (I) (we) last saw the deceased alive on April 21, 1960 and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE H. C. Diehl				22b. DATE 4/22/60			
22c. PHYSICIAN'S NAME (Type) H. C. Diehl,				22d. ADDRESS 39 W. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-60		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION (City, town, or county) (State) Eckhart, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. C. C. C.				25a. REC'D BY REGISTRAR DATE APR 25 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18,4042

4087

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Roy</u> Last <u>Potts</u>		4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/88</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>23</u> Hours <u>19</u> Min. <u>60</u>	IF UNDER 24 HRS. Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>K&S Tire Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Inglesmith, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Johnathan Potts</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Purcell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>4-22</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>16 Green St, Cumberland</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 19, 1960</u> that I last saw the deceased alive on <u>4-21-1960</u> , and that death occurred at <u>4-22-1960</u> AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>16 Green St, Cumberland, Md 21610</u>	
ACTUAL SIGNATURE <u>Dr. Johnson</u>		DATE SIGNED <u>4-24-60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Johnson</u>		ADDRESS <u>16 Green Street</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Near Artemas, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS <u>16 Green Street</u>	
24a. REC'D BY REGISTRAR <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1913

RECEIVED

1913

1913

4088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/24/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earnest Middle D. Last Rice		4. DATE OF DEATH Month April Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Rice		14. MOTHER'S MAIDEN NAME Helen Youngblood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
INFORMANT P.O.Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
17. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Cardiac Decompensation		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/24/60 , 19__, to 4/8/60 , 19__, that I last saw the deceased alive on 4/7/60 , 19__, and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 4/8/60			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE Apr 12 '60		24b. REGISTRAR'S SIGNATURE Charles L. K...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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STATEMENT OF DEBIT

Allegany Maryland Allegany

Quabertland 3/24/60

Allegany County Jail 3/24/60

Male White 3/24/60 8 60

Redford - Yarnall Maryland U. S. A.

George W. Rice Helen Youngblood
Allegany County Jail 3/24/60
Quabertland, Md.

3/24/60 7:30 PM 1/1/60

Dr. James A. Nelson 1/1/60
Quabertland, Md.

1/1/60 1/1/60

4089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Hamp</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>		d. STREET ADDRESS <u>Levels</u>	
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>A</u> Last <u>Saville</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>136-58-0939</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Vina Saville</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>136-58-0939</u>		16. SOCIAL SECURITY NO. <u>136-58-0939</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>8 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-3-1953</u> to <u>4-14-1960</u> , that I last saw the deceased alive on <u>4-13-1960</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>		ADDRESS (Street, city or town, state) <u>62 Greene St. 4-14-60</u>	
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/16 1960</u>		22b. DATE THEREOF <u>Wesley Chapel</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Points</u>		22d. LOCATION (City, town, or county) (State) <u>W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. M. Lee</u>		ADDRESS <u>Augusta W. Lee</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
ISM 9/58

1088

CERTIFICATE OF DEATH

1088

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1088

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4090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>S</u> Last <u>Schaffer</u>				4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/2/01</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Ready</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hartman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Chart</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplectic Stroke</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>60</u> , to <u>4-13</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4-13</u> , 19 <u>60</u> , and that death occurred at <u>7:29</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>58 Greene Street</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>L. Brings</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>Dr. L. Brings</u> <u>58 Greene Street</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/14/60</u>		<u>Sunset Manor Pl</u>		<u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. - Cumb Md</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

450-0

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4091 CERTIFICATE OF DEATH

64046

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 34 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 625 LAFAYETTE AVE.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH FRANCIS SCREEN Sr				4. DATE OF DEATH Month Day Year APRIL 25 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 26, 1902	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY B&O R. R.		11. BIRTHPLACE (State or foreign country) LONA CONING, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH SCREEN				14. MOTHER'S MAIDEN NAME JANET ROBERTSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-05-4494		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>lying cause last. (b) Congestive Heart Failure DUE TO (c) Myocardial infarction</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-17-60 , 19 60 , to 4-25 , 19 60 , that (I) (we) last saw the deceased alive on 4-25 , 19 60 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE William P James				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-26-60	
22c. PHYSICIAN'S NAME (Type) William P James, MD				22d. ADDRESS 4414 Centre St, Camb. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/60		23c. NAME OF CEMETERY OR CREMATORY Camp Ground Cemetery		23d. LOCATION (City, town, or county) (State) Tunnelton, W Va	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ruth E. Silcox Cumberland Maryland				25a. REC'D BY REGISTRAR DATE APR 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1900

AMERICAN RED CROSS
CENTRAL OFFICE
WASHINGTON, D.C.

1900



NAME	ADDRESS	CITY	STATE
Mr. J. H. Smith	123 Main St.	New York	N.Y.
Mr. W. B. Jones	456 Broadway	Chicago	Ill.
Mr. C. D. White	789 Madison Ave.	San Francisco	Calif.
Mr. E. F. Black	1010 Market St.	Los Angeles	Calif.
Mr. G. H. Green	1111 Broadway	Philadelphia	Penn.
Mr. I. J. Brown	1212 Chestnut St.	Boston	Mass.
Mr. K. L. Taylor	1313 Washington St.	San Antonio	Texas
Mr. M. N. Wilson	1414 Elm St.	Portland	Maine
Mr. O. P. Moore	1515 Pine St.	Seattle	Wash.
Mr. Q. R. Hall	1616 Oak St.	Denver	Colo.
Mr. S. T. King	1717 Maple St.	Minneapolis	Minn.
Mr. U. V. Lewis	1818 Birch St.	St. Paul	Minn.
Mr. W. X. Clark	1919 Cedar St.	Omaha	Nebr.
Mr. Y. Z. Adams	2020 Spruce St.	Portland	Me.
Mr. A. B. Baker	2121 Elm St.	San Jose	Calif.
Mr. C. D. Carter	2222 Oak St.	San Diego	Calif.
Mr. E. F. Evans	2323 Pine St.	San Francisco	Calif.
Mr. G. H. Fisher	2424 Maple St.	San Francisco	Calif.
Mr. I. J. Gibson	2525 Birch St.	San Francisco	Calif.
Mr. K. L. Grant	2626 Cedar St.	San Francisco	Calif.
Mr. M. N. Harris	2727 Elm St.	San Francisco	Calif.
Mr. O. P. Hill	2828 Oak St.	San Francisco	Calif.
Mr. Q. R. Howell	2929 Pine St.	San Francisco	Calif.
Mr. S. T. Hughes	3030 Maple St.	San Francisco	Calif.
Mr. U. V. Hunt	3131 Birch St.	San Francisco	Calif.
Mr. W. X. Ingram	3232 Cedar St.	San Francisco	Calif.
Mr. Y. Z. Jackson	3333 Elm St.	San Francisco	Calif.
Mr. A. B. Johnson	3434 Oak St.	San Francisco	Calif.
Mr. C. D. Keith	3535 Pine St.	San Francisco	Calif.
Mr. E. F. Lester	3636 Maple St.	San Francisco	Calif.
Mr. G. H. Little	3737 Birch St.	San Francisco	Calif.
Mr. I. J. Long	3838 Cedar St.	San Francisco	Calif.
Mr. K. L. Martin	3939 Elm St.	San Francisco	Calif.
Mr. M. N. Miller	4040 Oak St.	San Francisco	Calif.
Mr. O. P. Moore	4141 Pine St.	San Francisco	Calif.
Mr. Q. R. Nelson	4242 Maple St.	San Francisco	Calif.
Mr. S. T. Owen	4343 Birch St.	San Francisco	Calif.
Mr. U. V. Parker	4444 Cedar St.	San Francisco	Calif.
Mr. W. X. Quinn	4545 Elm St.	San Francisco	Calif.
Mr. Y. Z. Reed	4646 Oak St.	San Francisco	Calif.
Mr. A. B. Rogers	4747 Pine St.	San Francisco	Calif.
Mr. C. D. Russell	4848 Maple St.	San Francisco	Calif.
Mr. E. F. Scott	4949 Birch St.	San Francisco	Calif.
Mr. G. H. Stone	5050 Cedar St.	San Francisco	Calif.
Mr. I. J. Taylor	5151 Elm St.	San Francisco	Calif.
Mr. K. L. Turner	5252 Oak St.	San Francisco	Calif.
Mr. M. N. Vance	5353 Pine St.	San Francisco	Calif.
Mr. O. P. Webb	5454 Maple St.	San Francisco	Calif.
Mr. Q. R. White	5555 Birch St.	San Francisco	Calif.
Mr. S. T. Wright	5656 Cedar St.	San Francisco	Calif.
Mr. U. V. Young	5757 Elm St.	San Francisco	Calif.
Mr. W. X. Ziegler	5858 Oak St.	San Francisco	Calif.
Mr. Y. Z. Zimmerman	5959 Pine St.	San Francisco	Calif.
Mr. A. B. Ziegler	6060 Maple St.	San Francisco	Calif.



AMERICAN RED CROSS
CENTRAL OFFICE
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G261 4-18-60 et

4092

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>427 Waverly Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>G</u> Last <u>Seeders</u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 6, 1899</u>	
9. AGE (In years last birthday) <u>61 60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Fanny Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Degeneration</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/30</u> , 19 <u>60</u> , to <u>4/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/7</u> , 19 <u>60</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/9/60</u>							
ACTUAL SIGNATURE <u>Dr. L. Ley</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. L. Ley</u>				<u>456 N. Centre St.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Glenn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>(Near) Greenspring WVa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	

STATE OF MASSACHUSETTS
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64648

4122 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Savage</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Savage</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie Newman Shaffer</u>			4. DATE OF DEATH Month Day Year <u>April 24, 1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Feb. 23, 1877</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>	
13. FATHER'S NAME <u>Edward Newman</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Witt</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-8002</u>		17. INFORMANT <u>John M. Shaffer, Mt. Savage, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Long standing of R. V. Leg.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>April 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>60</u> , and that death occurred at <u>3 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>48 BRD AD WY</u> DATE SIGNED <u>4/25/60</u> ACTUAL SIGNATURE <u>Martin M. Rothstein M.D.</u> PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D. F.R.C.P. U.S.G.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Mt. Savage, Md.</u>		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence A. Leigler</u>		ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>					

4093 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/30/49	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Shannon Last Shannon		4. DATE OF DEATH Month April Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Roberts		14. MOTHER'S MAIDEN NAME Louise Heath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT P.O.Box 599 Address Cumberland, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO Chronic Nephritis (c) Senile Deterioration		INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/30/49 , 19____, to 4/22/60 , 19____, that I last saw the deceased alive on 4/22/60 , 19____, and that death occurred at 2:05P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 4/22/60			
ACTUAL SIGNATURE James E. McLean		M.D. 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-25-60	22c. NAME OF CEMETERY OR CREMATORY F'hg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Rust ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR APR 25 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Allegany County Infirmary
217 Glenn Street
Cumberland
Allegany
Maryland
Allegany

Louise
Shannon
April 22, 1900

Female White
2/21/1913
88

Honolulu
Washington, D. C.
U. S. A.

John Roberts
Louise Heath
P.O. Box 399
Allegany County Infirmary Records
Cumberland, Md.

Dr. James H. Robson
110 Greene St.
Cumberland, Md.

6/30/19
1/22/60
2:05P

Dr. James H. Robson
110 Greene St.
Cumberland, Md.

4125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg (Rural)				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #2 Box 188				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last SKIDMORE				4. DATE OF DEATH Month 4 Day 1 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Borden, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Skidmore				14. MOTHER'S MAIDEN NAME Susan Weitzel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-4049		INFORMANT Address Frostburg, Md. Mr. Harry Skidmore, R.D. #2, Box 188.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Myocardial Ischemia (c) Generalized Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH Immediate 10 yr. "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 20, 1960 to April 1, 1960 , that I last saw the deceased alive on April 1, 1960 , and that death occurred at 3:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alvin J. Walters		ADDRESS (Street, city or town, state) 48 Broad way		DATE SIGNED 4/3/60			
PHYSICIAN'S NAME (Type) Alvin J. Walters		Frostburg, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-60	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Burl H. Wooten			ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE APR 5 '60		
			24b. REGISTRAR'S SIGNATURE Arthur S. Hana				

CERTIFICATE OF DEATH

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4094 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>X</u> <u>Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>Rt. #5</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jeraldine</u> Middle <u>A.</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/22</u>		9. AGE (In years last birthday) <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Anthony Struntz</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ann Dickey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 10 0190</u>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myeloblastic leukemia</u> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11-60</u> to <u>4-23-60</u> , that I last saw the deceased alive on <u>4-23-60</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. J. Johnson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>16 Greene St Cumberland Md 42406</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Johnson</u>		<u>16 Green St.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 25, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10051

CERTIFICATE OF DEATH

10051

Age

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

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M
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4095 CERTIFICATE OF DEATH

64052

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 32 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KARL Middle McDONALD Last SMITH				4. DATE OF DEATH Month APRIL Day 15 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 1 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman				10b. KIND OF BUSINESS OR INDUSTRY Candy Company		11. BIRTHPLACE (State or foreign country) KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JARRETT SMITH				14. MOTHER'S MAIDEN NAME MARY CALDWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Asleep							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral vascular accident on 3-14-60							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3:14 19 60 to 4:15 19 60 that (I) (we) last saw the deceased alive on 4-14-19 60 and that death occurred 3:10 AM the causes and on the date stated above.							
22a. SIGNATURE Wm F Williams M.D.				22b. DATE SIGNED 4-15-60			
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS CENTER ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF Apr. 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE APR 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4053
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN lb <u>7 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rt. # 1 Oldtown</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Bear Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alvin</u> Last <u>Stallings</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/88</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Tolbert Stallings</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stallings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-2265</u>		17. INFORMANT Address <u>Sacred Heart Hospital Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, massive</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Post operative, following aortic resection</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>15-20 Min.</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery disease,</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 4, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Oldtown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G263 5/11/60 1wk

64054

CERTIFICATE OF DEATH

Reg. Dist. No.

4126

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zihlman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zihlman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. D. No 2 Frostburg, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Steele</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Anthony Logsdon</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Folk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Frostburg, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>15 yrs 33</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>60</u> , to <u>4/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>60</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin M. Rothstein</u> M.D.		ADDRESS (Street, city or town, state) <u>48 BROADWAY</u> DATE SIGNED <u>4/24/60</u>	
PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D. FROSTBURG, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pearl H. Mattingly</u>		24a. REC'D BY REGISTRAR <u>MAY 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

2013

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4097 CERTIFICATE OF DEATH

Reg. Dist. No.

4055

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>50 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>210 Pear Street</u>							
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>A</u> Last <u>STEWARD</u>				4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>EDWARD STEWARD</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE U known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214 05 6604</u>			
17. INFORMANT <u>CHART</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 19, 1960</u> to <u>April 29, 1960</u> , that I lost the deceased olive on <u>April 30, 1960</u> , and that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>Gina M. Glick</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Gina M. Glick</u> <u>126 N. Smallwood Street</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemeetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	
DATE <u>MAY 5 '60</u>							

DEPARTMENT OF HEALTH

1903

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CLIFFE & WILSON

RECEIVED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64056

4127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corriganville		c. LENGTH OF STAY IN 1b 22 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Corriganville		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Stuckey		4. DATE OF DEATH April 5, 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Derby, England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Holt		14. MOTHER'S MAIDEN NAME Eliza Moody	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Asa Stuckey, Corriganville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 450.0 DUE TO arteriosclerosis generalisata Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1960 to April, 1960 , that I last saw the deceased alive on April 4, 1960 , and that death occurred at 6:11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST., MT. SAVAGE, MD. DATE SIGNED ACTUAL SIGNATURE Otto Vogel M.D. PHONE: CO 4-4581 PHYSICIAN'S NAME (Type) Otto Vogel			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey S. Leigler		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DATE APR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

CERTIFICATE OF DEATH

File No. 100

1. NAME OF DECEASED OTTO VOGEL		2. SEX Male		3. AGE 38	
4. DATE OF DEATH April 11, 1934		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Germany	
10. OCCUPATION None		11. EDUCATION None		12. RELIGION None	
13. MARITAL STATUS Single		14. COLOR White		15. HEIGHT 5' 8"	
16. WEIGHT 150 lbs		17. BUILD Slender		18. COMPLEXION Fair	
19. PREVIOUS ILLNESSES None		20. MEDICAL HISTORY None		21. SURGICAL HISTORY None	
22. PHYSICIAN'S SIGNATURE [Signature]		23. COUNTY Baltimore		24. CITY Baltimore	
25. STATE Maryland		26. ZIP CODE 21201		27. REGISTRAR'S SIGNATURE [Signature]	
28. DATE OF REGISTRATION April 11, 1934		29. TIME OF REGISTRATION 11:00 AM		30. PLACE OF REGISTRATION Baltimore	

RECEIVED
MAY 11 1934
BALTIMORE, MD

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4098 CERTIFICATE OF DEATH

04057

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle J. Last SULLIVAN				4. DATE OF DEATH Month APRIL Day 30 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 17, 1903	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Grocery Firm		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S.A.							
13. FATHER'S NAME JOHN SULLIVAN				14. MOTHER'S MAIDEN NAME TERESA CALLAGHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 705-10-6037		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Cardiac				INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema & Fibrosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 19 58 to 30 April 19 60 , that (I) (we) last saw the deceased alive on 30 April 19 60 and that death occurred at 3:30 P.M. the causes and on the date stated above.							
22a. SIGNATURE Dr. Weisman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/2/60	
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN				22d. ADDRESS GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-60		23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Savage Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Benah H. Montesant				25a. REC'D BY REGISTRAR 23 E. Main, Frostburg, Md.		25b. REGISTRAR'S SIGNATURE DATE MAY 5 '60	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

CERTIFICATE OF DEATH

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DECEASED

DECEASED

DECEASED

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

SEX

SEX

DATE OF BIRTH

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PLACE OF BIRTH

CAUSE OF DEATH

CAUSE OF DEATH

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DATE OF INTERMENT



DATE OF INTERMENT

DATE OF INTERMENT

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VR A15 (4)
ISM 9/59

64058

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZA Middle C. Last SWEENE		4. DATE OF DEATH Month APRIL Day 3 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) SWANTON, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME AQUILE SHARPLESS	
14. MOTHER'S MAIDEN NAME LUCINDA PAUGH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL	
18. ADDRESS CUMBERLAND, MD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma stomach & extension to brain 160.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 3/28/60 to 4/1/60 , 19 60 that (I) (we) last saw the deceased alive on 4/1/60 , 19 60 , and that death occurred at 9:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED 4/1/60	
22c. PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS		22d. ADDRESS Algonquin Hotel Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-60	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Paula H. Montesano		25a. REC'D BY REGISTRAR APR 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hunt		25c. ADDRESS 23 East Main, Frostburg, Md.	

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES
NATIONAL BUREAU OF HEALTH STATISTICS
FEDERAL BUREAU OF SURVEY
40099 CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. OCCUPATION [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. MANNER OF DEATH [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]	
11. SIGNATURE OF REGISTRAR [Illegible]		12. SIGNATURE OF WITNESSES [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF NEXT OF KIN [Illegible]	
15. SIGNATURE OF CLERK [Illegible]		16. SIGNATURE OF CHIEF OF BUREAU [Illegible]	
17. SIGNATURE OF ASSISTANT CHIEF [Illegible]		18. SIGNATURE OF DEPUTY CHIEF [Illegible]	
19. SIGNATURE OF SECRETARY [Illegible]		20. SIGNATURE OF ASSISTANT SECRETARY [Illegible]	
21. SIGNATURE OF DEPUTY ASSISTANT SECRETARY [Illegible]		22. SIGNATURE OF CHIEF OF DIVISION [Illegible]	
23. SIGNATURE OF ASSISTANT CHIEF OF DIVISION [Illegible]		24. SIGNATURE OF DEPUTY CHIEF OF DIVISION [Illegible]	
25. SIGNATURE OF SECRETARY OF DIVISION [Illegible]		26. SIGNATURE OF ASSISTANT SECRETARY OF DIVISION [Illegible]	
27. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF DIVISION [Illegible]		28. SIGNATURE OF CHIEF OF OFFICE [Illegible]	
29. SIGNATURE OF ASSISTANT CHIEF OF OFFICE [Illegible]		30. SIGNATURE OF DEPUTY CHIEF OF OFFICE [Illegible]	
31. SIGNATURE OF SECRETARY OF OFFICE [Illegible]		32. SIGNATURE OF ASSISTANT SECRETARY OF OFFICE [Illegible]	
33. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF OFFICE [Illegible]		34. SIGNATURE OF CHIEF OF SECTION [Illegible]	
35. SIGNATURE OF ASSISTANT CHIEF OF SECTION [Illegible]		36. SIGNATURE OF DEPUTY CHIEF OF SECTION [Illegible]	
37. SIGNATURE OF SECRETARY OF SECTION [Illegible]		38. SIGNATURE OF ASSISTANT SECRETARY OF SECTION [Illegible]	
39. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF SECTION [Illegible]		40. SIGNATURE OF CHIEF OF BRANCH [Illegible]	
41. SIGNATURE OF ASSISTANT CHIEF OF BRANCH [Illegible]		42. SIGNATURE OF DEPUTY CHIEF OF BRANCH [Illegible]	
43. SIGNATURE OF SECRETARY OF BRANCH [Illegible]		44. SIGNATURE OF ASSISTANT SECRETARY OF BRANCH [Illegible]	
45. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF BRANCH [Illegible]		46. SIGNATURE OF CHIEF OF DIVISION [Illegible]	
47. SIGNATURE OF ASSISTANT CHIEF OF DIVISION [Illegible]		48. SIGNATURE OF DEPUTY CHIEF OF DIVISION [Illegible]	
49. SIGNATURE OF SECRETARY OF DIVISION [Illegible]		50. SIGNATURE OF ASSISTANT SECRETARY OF DIVISION [Illegible]	
51. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF DIVISION [Illegible]		52. SIGNATURE OF CHIEF OF OFFICE [Illegible]	
53. SIGNATURE OF ASSISTANT CHIEF OF OFFICE [Illegible]		54. SIGNATURE OF DEPUTY CHIEF OF OFFICE [Illegible]	
55. SIGNATURE OF SECRETARY OF OFFICE [Illegible]		56. SIGNATURE OF ASSISTANT SECRETARY OF OFFICE [Illegible]	
57. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF OFFICE [Illegible]		58. SIGNATURE OF CHIEF OF SECTION [Illegible]	
59. SIGNATURE OF ASSISTANT CHIEF OF SECTION [Illegible]		60. SIGNATURE OF DEPUTY CHIEF OF SECTION [Illegible]	
61. SIGNATURE OF SECRETARY OF SECTION [Illegible]		62. SIGNATURE OF ASSISTANT SECRETARY OF SECTION [Illegible]	
63. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF SECTION [Illegible]		64. SIGNATURE OF CHIEF OF BRANCH [Illegible]	
65. SIGNATURE OF ASSISTANT CHIEF OF BRANCH [Illegible]		66. SIGNATURE OF DEPUTY CHIEF OF BRANCH [Illegible]	
67. SIGNATURE OF SECRETARY OF BRANCH [Illegible]		68. SIGNATURE OF ASSISTANT SECRETARY OF BRANCH [Illegible]	
69. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF BRANCH [Illegible]		70. SIGNATURE OF CHIEF OF DIVISION [Illegible]	
71. SIGNATURE OF ASSISTANT CHIEF OF DIVISION [Illegible]		72. SIGNATURE OF DEPUTY CHIEF OF DIVISION [Illegible]	
73. SIGNATURE OF SECRETARY OF DIVISION [Illegible]		74. SIGNATURE OF ASSISTANT SECRETARY OF DIVISION [Illegible]	
75. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF DIVISION [Illegible]		76. SIGNATURE OF CHIEF OF OFFICE [Illegible]	
77. SIGNATURE OF ASSISTANT CHIEF OF OFFICE [Illegible]		78. SIGNATURE OF DEPUTY CHIEF OF OFFICE [Illegible]	
79. SIGNATURE OF SECRETARY OF OFFICE [Illegible]		80. SIGNATURE OF ASSISTANT SECRETARY OF OFFICE [Illegible]	
81. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF OFFICE [Illegible]		82. SIGNATURE OF CHIEF OF SECTION [Illegible]	
83. SIGNATURE OF ASSISTANT CHIEF OF SECTION [Illegible]		84. SIGNATURE OF DEPUTY CHIEF OF SECTION [Illegible]	
85. SIGNATURE OF SECRETARY OF SECTION [Illegible]		86. SIGNATURE OF ASSISTANT SECRETARY OF SECTION [Illegible]	
87. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF SECTION [Illegible]		88. SIGNATURE OF CHIEF OF BRANCH [Illegible]	
89. SIGNATURE OF ASSISTANT CHIEF OF BRANCH [Illegible]		90. SIGNATURE OF DEPUTY CHIEF OF BRANCH [Illegible]	
91. SIGNATURE OF SECRETARY OF BRANCH [Illegible]		92. SIGNATURE OF ASSISTANT SECRETARY OF BRANCH [Illegible]	
93. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF BRANCH [Illegible]		94. SIGNATURE OF CHIEF OF DIVISION [Illegible]	
95. SIGNATURE OF ASSISTANT CHIEF OF DIVISION [Illegible]		96. SIGNATURE OF DEPUTY CHIEF OF DIVISION [Illegible]	
97. SIGNATURE OF SECRETARY OF DIVISION [Illegible]		98. SIGNATURE OF ASSISTANT SECRETARY OF DIVISION [Illegible]	
99. SIGNATURE OF DEPUTY ASSISTANT SECRETARY OF DIVISION [Illegible]		100. SIGNATURE OF CHIEF OF OFFICE [Illegible]	

4117

CERTIFICATE OF DEATH

Reg. Dist. No.

64059

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANGELA Middle S. Last TACCINO				4. DATE OF DEATH Month April Day 10 Year 19 60			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-24-1901	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Gualtieri				14. MOTHER'S MAIDEN NAME Teresa Noce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Arthur Valenzano, Eckhart, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) 6 Day 7 Serial Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Apr 4, 1960 to Apr 10, 1960 that I last saw the deceased alive on Apr 10, 1960 and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Womc Lane M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Frostburg Apr 11 1960			
PHYSICIAN'S NAME (Type) Womc Lane M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-60		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bulah H. Montecant				ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR APR 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

420.1

4100 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Thrasher</u> Last <u>Thrasher</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/7/16</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>43</u> Days <u>43</u> Hours <u>43</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Kabrick</u>				14. MOTHER'S MAIDEN NAME <u>Emma Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Husband- James Thrasher- address Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial tamponade due to Rupture of Left Ventricle</u> DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY SCLEROSIS - ARTERIOSCLEROTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Diabetes</u> <u>Hypothyroidism</u> <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> <u>Hypothyroidism</u> <u>Obesity</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>3 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 1960</u> to <u>April 23, 1960</u> , that I last saw the deceased alive on <u>April 22, 1960</u> , and that death occurred at <u>1:39 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Amelsucan</u>				ADDRESS (Street, city or town, state) <u>59 GREENE ST</u> DATE SIGNED <u>4/23/60</u>			
PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN</u>				CUMBERLAND MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sonset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHORN</u>				ADDRESS <u>LONACONING, MD.</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE
VITAL STATISTICS ACT, CHAPTER 108, SECTION 1, OF THE
LAWS OF 1901, AS AMENDED.

4101 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 6/25/58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle W. Last Turner				4. DATE OF DEATH Month April Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1880	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maysville, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Turner				14. MOTHER'S MAIDEN NAME Elizabeth Veach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) Chronic Bronchiectasis						INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Allegany	(State) Md.		
21. I certify that I attended the deceased from 6/25/58 , 19___, to 4/15/60 , 19___, that I last saw the deceased alive on 4/15/60 , 19___, and that death occurred at 8:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 4/16/60							
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/60	22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or county) (State) Flintstone Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR APR 19 60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraw		

1025

Allegany

West Virginia

Overland

Philadelphia

6/25/58

Charles

Turner

W.

April

1958

60

Male White

1/13/1980

80

Retired - Farmer

Farmer

Wayville, West Virginia, U. S. A.

William Turner

Elizabeth Vernon

Overland, Mo.

P.O. Box 909

Allegany County, West Virginia

None

6/25/58

6/25/58

6/25/58

6:58

6/25/58

Dr. James E. Nolan

Overland, Mo.

Wife

Elizabeth

Overland

Overland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Rural Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Rt. 4, Cumberland</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>VIRGINIA</u> <u>DANARIS</u> <u>TWIGG</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1876</u>		
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Josiah E. Eyler</u>				14. MOTHER'S MAIDEN NAME <u>Urilla Clark</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. John W. Davis, Rt. 4, Cumberland, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ </div>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 27, 1960</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor Cemetery</u>		22d. LOCATION (City, town, or county) <u>Allegany Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		DATE OF MARRIAGE _____	
NAME OF SPOUSE _____		NAME OF CHILD(REN) _____	
NAME OF NEXT OF KIN _____		ADDRESS _____	
CITY _____		STATE _____	
ZIP CODE _____		COUNTY _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		SIGNATURE OF EXAMINER _____	
PRINTED NAME OF EXAMINER _____		TITLE OF EXAMINER _____	
SIGNATURE OF WITNESS _____		PRINTED NAME OF WITNESS _____	
SIGNATURE OF DECEASED _____		PRINTED NAME OF DECEASED _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>6 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, near Cumberland</u> d. STREET ADDRESS <u>Route 3, Bedford Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS ALBERT WARNICK</u> 4. DATE OF DEATH Month Day Year <u>April 10, 1960</u> <u>19</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 12, 1908</u> 9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u> 13. FATHER'S NAME <u>Henry Warnick</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u> 14. MOTHER'S MAIDEN NAME <u>Agnes Handley</u>		11. BIRTHPLACE (State or foreign country) <u>Beryl, West Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Vada Warnick</u> <u>Rt. 3, Bedford Road</u> <u>Cumberland, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sclerosis and Thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 10, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u>		ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 12 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>S. S. Kneel</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

420.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-1-29		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION Attorney		8. MARITAL STATUS Single		9. EDUCATION High School	
10. SOCIAL SECURITY NUMBER [REDACTED]		11. RESIDENT ADDRESS [REDACTED]		12. CITY Baltimore	
13. STATE Maryland		14. ZIP CODE 21201		15. COUNTY Baltimore	
16. DATE OF DEATH 4-4-68		17. TIME OF DEATH 11:00 AM		18. PLACE OF DEATH Home	
19. CAUSE OF DEATH Suicide		20. MANNER OF DEATH Homicide		21. MEDICAL HISTORY None	
22. SIGNATURE OF EXAMINER [REDACTED]		23. SIGNATURE OF WITNESS [REDACTED]		24. SIGNATURE OF DECEASED [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF DECEASED [REDACTED]		27. SIGNATURE OF DECEASED [REDACTED]	
28. SIGNATURE OF DECEASED [REDACTED]		29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF DECEASED [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF DECEASED [REDACTED]		33. SIGNATURE OF DECEASED [REDACTED]	
34. SIGNATURE OF DECEASED [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF DECEASED [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF DECEASED [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]	
40. SIGNATURE OF DECEASED [REDACTED]		41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF DECEASED [REDACTED]	
43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF DECEASED [REDACTED]		45. SIGNATURE OF DECEASED [REDACTED]	
46. SIGNATURE OF DECEASED [REDACTED]		47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF DECEASED [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF DECEASED [REDACTED]		51. SIGNATURE OF DECEASED [REDACTED]	
52. SIGNATURE OF DECEASED [REDACTED]		53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF DECEASED [REDACTED]	
55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF DECEASED [REDACTED]		57. SIGNATURE OF DECEASED [REDACTED]	
58. SIGNATURE OF DECEASED [REDACTED]		59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF DECEASED [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF DECEASED [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]	
64. SIGNATURE OF DECEASED [REDACTED]		65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF DECEASED [REDACTED]	
67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF DECEASED [REDACTED]		69. SIGNATURE OF DECEASED [REDACTED]	
70. SIGNATURE OF DECEASED [REDACTED]		71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF DECEASED [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF DECEASED [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]	
76. SIGNATURE OF DECEASED [REDACTED]		77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF DECEASED [REDACTED]	
79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF DECEASED [REDACTED]		81. SIGNATURE OF DECEASED [REDACTED]	
82. SIGNATURE OF DECEASED [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF DECEASED [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF DECEASED [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]	
88. SIGNATURE OF DECEASED [REDACTED]		89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF DECEASED [REDACTED]	
91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF DECEASED [REDACTED]		93. SIGNATURE OF DECEASED [REDACTED]	
94. SIGNATURE OF DECEASED [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF DECEASED [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF DECEASED [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]	
100. SIGNATURE OF DECEASED [REDACTED]		101. SIGNATURE OF DECEASED [REDACTED]		102. SIGNATURE OF DECEASED [REDACTED]	

4118 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 Maple Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELL</u> Middle <u>M.</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Y. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Jane Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Frostburg, Md.</u> <u>Miss Lillian Williams, 209 Maple St.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443x</u> IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>several</u> <u>years</u> <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 25 1957</u> , 19 <u>60</u> , to <u>Apr 29 1960</u> , that I last saw the deceased alive on <u>Apr 25 1960</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>WOM Lane</u> M.D.				ADDRESS (Street, city or town, state) <u>Frostburg Md</u> DATE SIGNED <u>4-30-60</u>			
PHYSICIAN'S NAME (Type) <u>WOM Lane MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Monticant</u> ADDRESS <u>Hafer Funeral Home 23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

1

[Faint, mostly illegible handwritten text, possibly a medical or legal record, covering the majority of the page.]

4104 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cumberland Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Wilson Last Wilson		4. DATE OF DEATH Month April Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, -78
9. AGE (In years lost birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Loughrie		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Porter Wilson McCool, Md	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Congestive Heart Failure DUE TO (b) Bronchogenic Carcinoma DUE TO (c) lying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date of nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/15 , 19 60 to 4/5 , 19 60 , that I last saw the deceased alive on 4/5 , 19 60 , and that death occurred at 8:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Les H. Ley M.D.		ADDRESS (Street, city or town, state) 156 N. Centre St. Allegany, Md	
PHYSICIAN'S NAME (Type) Dr. L. Ley		DATE SIGNED 4/6/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/60	22c. NAME OF CEMETERY OR CREMATORY Barnard	22d. LOCATION (City, town, or county) (State) Sanitely, Md
23. FUNERAL DIRECTOR'S SIGNATURE Edw. J. Westernport, Md		24a. REC'D BY REGISTRAR APR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF LABORATORY MEDICINE
WASHINGTON, D.C.

CERTIFICATE OF DEATH

1104

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of attending physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4119 CERTIFICATE OF DEATH

64066

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Olive Middle Mae Last Wilson				4. DATE OF DEATH Month April Day 20th Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14th, 1884	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Hanson				14. MOTHER'S MAIDEN NAME Frances Duggan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 213-09-6571-A		17. INFORMANT J. Robt. Wilson Address 162 Maple St. F'bg. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertension DUE TO (c) Sudden 2 years				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1958 to 1960 , that (I) (we) last saw the deceased alive Apr 20 1960, and that death occurred Apr 20 1960 from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				22b. DATE SIGNED Apr 22/1960			
22c. PHYSICIAN'S NAME (Type) W. O. McLane				22d. ADDRESS 167 E. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-23-60		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	
23d. LOCATION (City, town, or county) Frostburg, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durrant ADDRESS Frostburg, Md.				25a. REC'D BY REGISTRAR APR 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64667

4128

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luke</u> c. LENGTH OF STAY IN 1b <u>30 Minutes</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>W. Va. Paper Co. Mill Yard.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Young</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foundry & Machine</u>	
11. BIRTHPLACE (State or foreign country) <u>Westernport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-01-1367</u>	
17. INFORMANT <u>Hugh Wilson-Luke, Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 3, 1960</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boral - Westernport, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 8 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FROSTBURG, RT. 1,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle WINEBRENNER Last WINEBRENNER		4. DATE OF DEATH Month APRIL Day 29, Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 17, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79	
11. IF UNDER 24 HRS. Days 79		12. Hours 79	
13. Min. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER	
10b. KIND OF BUSINESS OR INDUSTRY FIRE CLAY MINES		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAAC WINEBRENNER	
14. MOTHER'S MAIDEN NAME MARGARET ANN CROWE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 213-10-9900	
16. SOCIAL SECURITY NO. 213-10-9900		17. INFORMANT MRS. DOROTHY HOUSEL, R.D. 2, FROSTBURG,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary fibrosis DUE TO (c) 20th several years		INTERVAL BETWEEN ONSET AND DEATH 20th several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 26, 1960 , to Apr 29, 1960 , that (I) (we) last saw the deceased alive on Apr 28, 1960 , and that death occurred 8:57 AM , from the causes and on the date stated above.			
22a. SIGNATURE W O Mc Lane		22b. DATE SIGNED Apr 29/1960	
22c. PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-1-60	
23c. NAME OF CEMETERY OR CREMATORY Johnson's Cemetery		23d. LOCATION (City, town, or county) (State) Garrett County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. K. Duret		25a. REC'D BY REGISTRAR DATE MAY 3 '60	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

ALSO
CERTIFICATE OF DEATH

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ALSO

8 HRS.

MINOR HOSPITAL

5 HRS.

NOV. 14, 1930

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10-10-000

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